Western Highlands Network
A LOCAL MANAGEMENT ENTITY

Lanier M. Cansler, Secretary
2001 Mail Service Center
Raleigh, NC 28699-2001

Wednesday, February 10, 2010

Dear Secretary Cansler:

We look forward to seeing you, Mike Watson and Luckey Welsh Friday morning, March 5th. We will be meeting at Access II Care's offices in Asheville and will include staff from Western Highlands and Access II Care. Our aim is to discuss some of the unique challenges in serving individuals with significant mental illness and substance use disorders who also suffer from chronic medical conditions (known as the Quadrant 4 population in a commonly used schematic for describing integrated care approaches). We would like to discuss how this high risk, high cost population can be served effectively with limited modifications in the service delivery management system. Through the establishment of standardized protocols and processes, we can first, increase primary care providers' confidence in treating the Aged Blind and Disabled population with co-morbid mental health and substance use conditions; and second, help behavioral health providers improve their identification of chronic medical conditions and their coordination with medical care. In addition to providing better care and improved outcomes, we believe we can achieve substantial cost savings, especially in ED and inpatient utilization and in pharmacy costs. Finally, we believe this model is replicable and can become a new standard for how the Q4 population is to be served by CCNC, the LMEs, primary care providers, the CABHAs and other specialized providers.

Western Highlands Network and Access II Care have been collaborating for a number of years. Care managers at Access II Care work closely with care coordinators at Western Highlands; both of our medical directors have been involved in jointly developing standards of care and reviewing complex cases. Based on our preliminary findings as well as more formal research conducted in other settings, we are confident that the success CCNC has demonstrated in the treatment and management of diabetes, asthma and other chronic conditions can also occur with this population.

In order to illustrate what can be accomplished, consider the following case example:

Middle aged female with history of Type I Diabetes, Seizure Disorder, Hepatitis C, Substance Abuse and Bipolar Disorder residing in a Family Care Home:

- *In the year prior to care management services she had 11 medical hospitalizations, four MH/SA hospitalizations, 11 ER visits and three arrests.*
- *Her case was assessed and care management services were initiated.*

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- *Access II Care CM coordinated treatment team meetings and the sharing of patient information. Treatment team meetings were held at least monthly. The treatment team consisted of:*
    - *Patient*
    - *Representative from WHN responsible for care coordination and utilization review*
    - *Representative from WNC Ray of Hope (private provider)*
    - *Primary Care Provider from WNCCHS (Asheville-based FQHC)*
    - *Substance Abuse Counselor from WNCCHS*
    - *RN Case Manager for Mission Hospital*
    - *Access II Care CM*

- *In mid November the team developed and implemented a diversion plan between WNC Ray of Hope and Mission Hospital related to ER visits where cocaine abuse was determined to be a factor.*

- *Additional Access II Care interventions included but were not limited to visits to the patient at the family care home to provide diabetes education and support, assistance with obtaining a new primary care home, facilitation of involuntary commitment related to substance abuse, participation in discharge planning meetings at Copestone psychiatric inpatient unit, patient support and coordination of care related to ADATC commitment and completion of a voluntary 28 day stay.*

- *Patient now living at Family Care Home and attending Pathways of Change intensive outpatient program five days a week and attending AA/NA meetings daily on the weekend.*

- *During the 10 months of Access II Care CM intervention, inpatient medical utilization was reduced by 64%, MH/SA hospitalizations by 25% and ED utilization by 55%; and the patient had no further arrests.*

- *Total Medicaid Inpatient and ED Cost for one year prior to intervention: $46,630.*

- *Total Medicaid Inpatient and ED Cost during intervention year: $23,500.*

We have been able to produce comparable dramatic outcomes with many other individuals. In the future, we hope to increase the population we serve by:

1. Improving the mechanisms to **identify** current and future high risk, high cost consumers in both the behavioral health and medical practices.

2. Continuing to develop a comprehensive system between WHN and CCNC for referring consumers for **integrated care coordination** for Medicaid and State funded consumers meeting Quadrant IV criteria.

3. Developing a system wide **treatment network** that promotes appropriate standards of care and formalizes medical/behavioral health protocols for the identification and treatment for target individuals.

Identification and Referral:

In order to improve the quality of care and reduce the need for high cost emergency and crisis services we must begin by developing formal mechanisms for identifying consumers that are currently, or at risk of, becoming part of the Q4 population. We propose to do this by:

1. Jointly redesigning the Access Screening Triage and Referral Form (STR) to more fully assess medical conditions of consumers entering the behavioral health system; as a consequence, more Q4 consumers will be identified and appropriately referred.

2. Collaborating with the WHN behavioral health provider network to develop a comprehensive clinical assessment which includes a uniform medical screening tool to identify current and emerging medical conditions, as well as referral and follow-up protocols.
3. Establishing standardized protocols for physicians in the CCNC network to refer consumers who have chronic medical and behavioral conditions and are unstable.
4. Identifying Q4 consumers through the WHN/CCNC retrospective review processes, including:
    a. Quarterly review of CCNC's real time hospital and paid claims data
    b. CCNC medication reconciliation requests from pharmacists
    c. Ongoing service authorization reviews by WHN utilization management staff
    d. Ongoing provider monitoring of behavioral health providers' screening and follow-up regarding chronic medical conditions through the WHN Monitoring Unit.

Integrated Care Coordination (ICC):

After consumers are identified as Q4 consumers, they will be referred for care coordination. WHN and CCNC staff will work as an integrated team to access and coordinate services for referred Q4 consumers. The team will strive to assure quality care while reducing the need for higher cost crisis and inpatient services (see Attachment A).

Team activities will include:

- Implementing protocols for exchange of information between behavioral health and primary care, including the use of electronic technologies.
- Establishing appropriate care plans and ensuring a comprehensive crisis plan for newly referred Q4 consumers; review of care and crisis plans for established consumers with Q4 providers, including CABHAs and primary care.
- Referring Q4 consumers to medical/behavioral providers that have been designated by WHN and CCNC as Q4 provider sites.
- Referral for medication reconciliation. It is anticipated that this activity could yield significant savings to the Medicaid system through the reduction of unnecessary Medicaid reimbursed prescription drugs.
- Review of consumer outcomes to document improved clinical care and cost savings through reduced need for crisis and inpatient services.
- Assuring that no matter where the Q4 consumer shows up in the system, the provider is immediately engaged to provide transitional care back to the consumer's previous level of care or demonstrate to all Q4 Team staff why consumer must be moved to a higher level of care, including projected length of stay with accompanying utilization management of that higher level of care.

Integrated Behavioral/Medical Provider Network:

After a Q4 consumer is identified and referred for care coordination, the ICC team will establish a medical/behavioral health home with one of the designated Q4 providers. All Q4 providers

provide basic MH/SA services, including medication management. Consumers needing specialized services will continue to be referred to appropriate providers, including CABHAs with a commitment to integrated care. At present, WHN has established relationships with the following integrated care sites:

- Western North Carolina Community Health Services (WNCCHS)- Serves Buncombe County and is established as a Federally Qualified Health Clinic (FQHC)
- Blue Ridge Community Health- Serves Henderson County and some Transylvania County consumers and is established as a FQHC.
- Polk Wellness Center- Serving Polk County
- Bakersville Clinic- Serving Mitchell County

Other potential partners include:

- Rutherford Free Clinic- Serving Rutherford County
- Hot Springs Health Clinic- Serving Madison County
- Transylvania Health Clinic- Serving Transylvania County

In areas where no Q4 provider has been established, WHN will work with CCNC to establish a formal relationship between a designated Critical Access Behavioral Health Agency (CABHA) and an existing medical provider.

In addition, in order to facilitate appropriate communication and resources to our most rural counties, WHN will employ the use of its telemedicine/telepsychiatry network; most network sites provide both behavioral health and medical services.

Benefits and Outcomes:

Based on our experience to date, we are confident this model:

1. Improves access to medical and behavioral health care for Q4 consumers.
2. Improves quality of life for consumers. Improved coordination between medical and behavioral health practitioners.
3. Improves access to psychiatric consultation for medical practitioners.
4. Decreases use of high cost crisis, Emergency Department and inpatient services.
5. Decreases costs of prescription drugs.
6. Encourages more providers to offer integrated care to Q4 consumers.

Challenges to Implementation:

We have identified some specific areas where DHHS support would improve the effectiveness of the model.

1. We would like DMH to recognize the need for additional time for the screening, triage and referral of Q4 consumers.
2. We would like DMH to require that CABHAs identify and refer Q4 consumers for LME-CCNC care coordination.
3. We would like to increase WHN's care coordination resources, possibly through a PMPM for the Q4 population.

4. We advocate for rapid approval and implementation of the following two components of the CCNC Accelerated Plan:
    a. Employment of a network psychiatrist.
    b. Additional care coordination.
5. Consider implementation of a PM/PM for integrated PCPs.
6. We would like to have more leverage with "Medicaid only" providers within the WHN provider network.
7. We would like DHHS to establish specific standards for providers wishing to serve Q4 consumers.

From discussions in other settings, we know that providing cost-effective services to this population is a priority for the Department. We also know that the Department faces extraordinary budgetary pressure both this year and next. However, we believe that an investment in fully integrated care coordination will both improve health outcomes and save State and Medicaid resources. We are eager to discuss our current experience with this model and our ideas regarding the benefits which would accrue from its possible expansion.

Please let us know if there is additional information we can provide you before our meeting or have available on site during your visit.

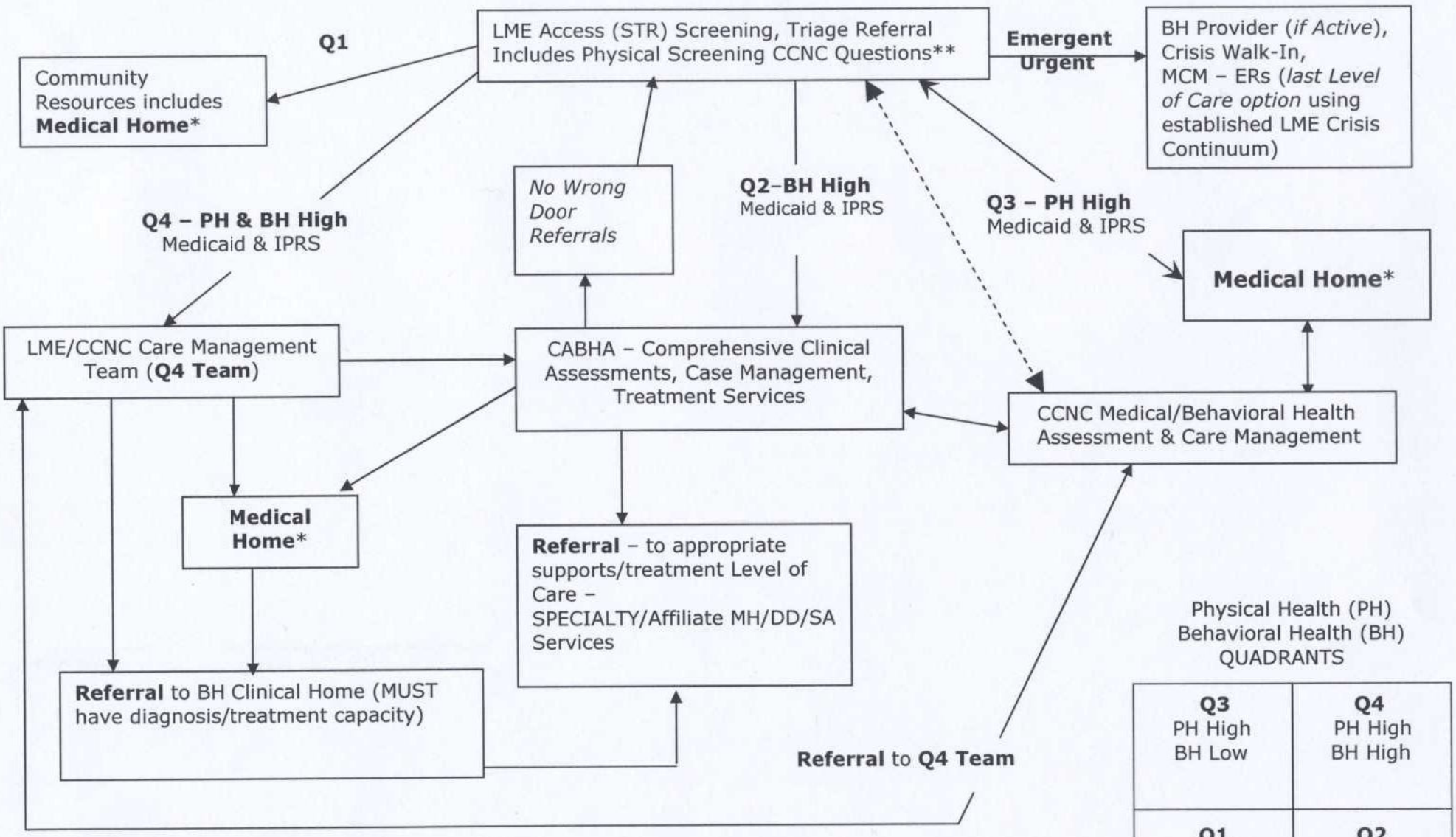
Sincerely,

Arthur Carder, CEO
Western Highlands Network

Jennifer Wehe, Executive Director
Access to Care of WNC

cc: Mike Watson
Luckey Welsh
Senator Martin Nesbitt

Integrated Screening, Referral & Coordination for ALL Physical Health (PH)/Behavioral Health (BH) Quadrants



Physical Health (PH)
Behavioral Health (BH)
QUADRANTS

Q3 PH High BH Low	**Q4** PH High BH High
Q1 PH Low BH Low	**Q2** PH Low BH High

***ALL Medical Homes** have referral capacity to community/medical specialties.
** No matter what Quadrant, LME Access may refer to **Medical Home**

2/9/10 WHN Version 3.0

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